In the Matter Of:

JONATHAN RICHARDSON

-v-

COMMISSIONER, INDIANA DEPT. OF CORRECTION

Loren Schechter, M.D.

January 26, 2024

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
EVANSVILLE DIVISION

JONATHAN RICHARDSON aka AUTUMN CORDELLIONE,	)	
Plaintiff,	)	Civil Action No. 3:23-cv-00135-RLY-CSW
-v-	)	
COMMISSIONER, INDIANA DEPARTMENT OF CORRECTION,	)	
Defendant.	)	

The recorded videoconference deposition upon oral examination of LOREN SCHECHTER, M.D., a witness produced and sworn remotely before me, Sherry D. Lenn, RPR, and Notary Public in and for the County of Warrick, State of Indiana, taken on behalf of the Defendant, remotely via Zoom videoconference on January 26, 2024, at 2:38 p.m. EST, pursuant to the Federal Rules of Civil Procedure.

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(All participants appearing by videoconference)

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(Exhibits 25, 27, and 28 were not referred to.)

COURT REPORTER: My name is Sherry Lenn, an associate of Stewart Richardson Deposition Services.

Today's date is January 26, 2024. The time is 2:38 p.m. Eastern Standard Time. This deposition is being held via Zoom videoconference.

The deponent's name is Dr. Loren Schechter. This case is filed in the United States District Court for the Southern District of Indiana in the matter of Autumn Cordellione, et al. vs. Commissioner of Indiana Department of Correction, Civil Action No. 3:23-cv-00135-RLY-CSW.

Will counsel please identify themselves and any persons present with you for the record starting with counsel for the Plaintiff, please?

MR. FALK: Ken Falk and Gavin Rose for the plaintiff Autumn Cordellione.

MR. CARLISLE: Alex Carlisle, Kate Meltzer, Rebekah Durham, Bradley Davis for the defendant.

COURT REPORTER: Does anyone have an objection to me administering the oath via Zoom?

MR. FALK: No. No from plaintiff.

MR. CARLISLE: No.

COURT REPORTER: Thank you.

LOREN SCHECHTER, M.D.,

called as a witness by the Defendant, having been first duly sworn, was examined and testified as follows:

EXAMINATION

QUESTIONS BY MR. CARLISLE

Q Good afternoon, Doctor. How are you?

A Fine. Thanks. How are you.

Q Doing well. My name is Alex Carlisle with the Indiana Attorney General's Office. I represent the defendant in this case. You've been deposed before, correct?

A I have.

Q All right. How many times about?

A Over 50.

Q Okay. I'm going to skip the formalities then. I'll just remind you you're under oath. You understand that?

A Yes.

Q And if you answer a question, I'm going to assume you understood it.

A Okay. As I said, I apologize. If my phone goes off, I may just have to grab it for a minute. We're just -- a couple things going on in the OR right now.

Q That's fine. I understand you're on call, right?

All right. So you're a surgeon?
A Yes.
Q You perform gender confirmation surgeries for transgender patients?
A I do, among other procedures.
Q Okay. And today when I say surgery, can we agree that I'm referring to gender confirmation surgery?
A Okay.
Q Great. And if necessary, we can use a more specific term like orchiectomy?
A Sure.
Q Or vaginoplasty, hysterectomy?
A Okay.
Q Okay. All right. Let's start with what is your role in the patient's gender dysphoria diagnosis?
A So as we've said, I'm a surgeon. I work in a multi-disciplinary manner, caring for people who, among other diagnoses, may have gender dysphoria. In doing so, I perform gender affirming or gender confirming procedures.

I don't make the diagnosis of gender dysphoria, but I work with primary care professionals, mental health professionals who typically make that diagnosis, and I work with them in a collaborative fashion as to whether surgery is

an appropriate step for the patient.
Q Okay. Apart from surgery, do you recommend other treatment options for patients for gender dysphoria?
A Well, my practice is a surgical practice, so, for example, I don't prescribe hormones.
Q All right. So if you're going to be treating a patient with gender dysphoria, it's limited to the surgical options?
A I don't provide counseling or mental health services nor do I prescribe hormones. My -- my practice is a surgical practice.
Q Okay. So by the time you are involved in the treatment for a patient with gender dysphoria, that person has been diagnosed with gender dysphoria?
A I would say that's generally true. On rare occasions someone may make it to the office who may not have yet carried a diagnosis, in which case our office will refer them to people who can assist.
Q Okay. If a patient with gender dysphoria is presented to you, has that patient already been recommended to receive a type of surgery?
A So the answer is it -- it depends. In my practice, I don't necessarily have to have received letters confirming readiness for surgery at the time of

consultation because I think personally the patient needs to see a surgeon, speak with a surgeon, hear about a procedure, risks and benefits and the options, and then go back to their primary care professional and or their mental health professional prior to deciding as to whether surgery would be indicated.

Q Okay. And is that because it's your opinion that the surgeon is in the best position to inform the patient of the risks, benefits, and options of surgery?

A Well, I think -- I think it's a bigger picture. The process for surgery or the informed consent process is just that. Hearing about the procedure and the specifics about the procedure as it relates to particular surgical issues or surgical risks fall within the purview of the surgeon.

Excuse me one second.

MR. CARLISLE: Okay.

(A brief recess was taken.)

A I apologize. So the surgeon -- the responsibility of the surgeon is to discuss the surgical risks benefits, options, et cetera, but that's one component of the informed consent process. So it's my opinion that not only does the patient need to

hear from the surgeon, but the patient also needs to take that information back and consider the impact of surgery on other aspects of their life. And those are typically also addressed with primary care professionals, mental health professionals, therapists, et cetera.

Q So can a patient have informed consent for surgery if he or she has not consulted with a surgeon?

A Well, I think a patient can't undergo -- unless there's an emergency surgery can't undergo surgery without an informed consent discussion with the surgeon.

Q Is there any circumstance where gender-conforming surgery would be performed on an emergency basis?

A Well, sequelae. So I've had, for example, people who have had self-surgery, amputated body -- or attempted to amputate body parts where there's bleeding that needs to be stopped, which would be emergent that wouldn't be necessarily the definitive procedure. That would be addressed at preventing loss of -- of life and stopping bleeding.

Q So if you have a patient who has attempted auto-castration, let's say, and they're bleeding and you see them for an emergency surgery, your

main goal is to stop the bleeding, correct?
A Stabilize the patient, whether there's -- when it occurred, is there infection, stabilize the patient, do they need a urinary catheter. There could be a number of -- of things involved but generally performed on an emergent basis.
Q But you wouldn't at that time go ahead and perform a vaginoplasty, let's say?
A I wouldn't do a vaginoplasty. It may require an orchiectomy if the -- if the testicle or the spermatic cord have been irreparably damaged or bleeding or need to be removed at that point.
Q Great. And so in circumstances where there is no damaged tissue like what you're describing, would a gender-conforming surgery ever be performed on an emergency basis?
A Well, I would say the majority of procedures that I perform for gender-affirming or gender-confirming surgery, like most surgeries, including, for example, most cancer surgeries, are elective in the sense that they're not designed for -- to save immediate loss of life or limb, for example.
Q Going back to informed consent, what are the requirements for informed consent in a patient like the plaintiff? And maybe if I can -- a patient who

wants feminizing genital surgery, what would the informed consent look like for that patient?

A Yeah. So I haven't personally examined, so you're referring to a generic patient?

Q Yes.

A Okay. So a typical scenario for -- for my practice would be a patient would be seen in our office. As with any patient seeking a -- the surgical service, we would interview the patient. I would interview the patient, discuss goals, expectations, medical history, family history, social history, et cetera, perform a physical examination, discuss the procedure, discuss the risks of the procedure, potential benefits of the procedure, options of undergoing the procedure or not undergoing the procedure. We typically use decisional aids, so that would include a combination of both written and visual information. So representative photos -- photographs of representative patients, written information that would support our discussion, allow the patient, for example, to review that information following our office procedure.

Depending upon the particular procedure -- if we're discussing vaginoplasty, the patient would meet with other members of our team, which would

typically include social work, a patient navigator, a pelvic floor physical therapist. At that point if the patient expressed an interest, we would -- in proceeding with surgery, we would ask them to go home, consider our information, contact our office should they have additional questions. Our office, usually our social worker, would then work with the patient in receipt of letters of assessment for primary care and/or mental health professional. Those letters -- and then the consent is memorialized typically with a series of documents where the patient reads, signs, initials and actually takes a short quiz to demonstrate their understanding of the material.

Q So that's quite an extensive list. I understand you do not know whether the plaintiff in this case has received any or all of those items?

A I do not know.

Q Okay. As part of your -- as part of your informed consent process, how much time do you spend discussing the risk of complications?

A I would anti- -- I would estimate that my time with the patient is probably 45 minutes plus or minus. I would say on average it's a couple of hours in our office in meeting with the various people who

we've just discussed followed by all the follow-up work, typically subsequent communication, whether in person or electronic with our nurse, our physician assistant, our social worker, our navigator depending upon particular circumstances.

Q As part of your informed consent process, how much time do you spend discussing data related to long-term outcomes?

A So part of my -- much of what my discussion is are the outcomes of my surgery but -- but tailored to the particular goals and expectations of the patient.

Q Okay. And did you say how long you spend discussing outcomes?

A That's most of the procedure -- or most of the consultation. A description of the -- following my history and physical is then a description of the procedure, a description of risks, a description of benefits and a description of options which includes not undergoing a procedure.

Q All right. Do you -- do you discuss studies like the sources you cited in your report for this case? Do you discuss those types of studies with your patients?

A I typically discuss my outcomes, my experience, as

well as general -- the general knowledge in the field. I don't necessarily discuss an individual study. Perhaps on occasion a patient may bring up a particular request or a technique that may involve a study in which case we would discuss it.

Q All right. So if I'm understanding correctly, you do not provide systematic data that may come from a study on surgeries to your patients during the informed consent process?

A No. I provide my experience and the general knowledge of the field. As to whether I discuss one particular study or not may depend upon the nature of the request.

Q Is there a waiting period for gender-confirmation surgery?

A Yes, in the sense that our wait lists are probably close to two years for a surgery.

Q And when does that two-year period start?

A Generally after I've seen the patient.

Q In that two-year interim between when you first see the patient and surgery, how many visits do you have with the patient?

A Again, that would depend on the nature of the request or the particular patient. We'll have the initial consultation. We always invite people back

for in-person consultations, but not uncommonly we may speak by phone or by electronic means.

Q Have you ever declined to perform gender-confirmation surgery for a patient who requested it?

A Yes.

Q How many times?

A I can't recall the number of times, but not every patient who we see -- who I see do I perform surgery on, whether their choice or a medical decision on my part.

Q Would you say you've declined to perform surgery for a patient who requested it more than ten times?

A Yes.

Q More than 20, 30? Can you give me an estimate?

A In my career, yes, more than 30.

Q Okay. All right. I want to talk about surgery for non-transgender individuals. So I assume you're familiar with the term cisgender?

A Yes.

Q Okay. And what does that mean to you?

A A person who -- a person whose gender identity is consistent with their -- with their physical anatomy, morphology, typically secondary sexual characteristics.

Q Okay. So let me ask if you perform a surgery that removes a cisgender man's penis and testicles, can he thereafter father a child naturally?

A Not after testicles are removed; however, I have performed and continue to perform reconstructive surgery for cisgender men secondary to cancer or trauma or birth-related conditions. So the ability to produce sperm would depend on testicles. So I've performed phalloplasty for men who are capable of producing sperm.

Q All right. But if you have a cisgender man and you perform an orchiectomy, you can't father a child naturally after that procedure, right?

A If both testicles are removed, he cannot. If one testicle is removed, potentially he could, although, again, we're speaking theoretically because, of course, not all cisgender men are able to successfully produce sperm that are capable of impregnating a person.

Q So in a case with a cisgender man who is capable of producing sperm to impregnate someone, if you perform an orchiectomy on him, that procedure will sterilize him, correct?

A If the person is fertile before surgery and both testicles are removed, of course unless if

undergone sperm preservation prior to that, they would not be able to produce sperm to impregnate a person.

Q And when -- would you ever perform a -- an orchiectomy on a cisgender man without the presence of pathology or diseased tissue?

A So generally speaking, although that's one of the cases that I'm involved in right now, is a cisgender man with a medical condition, Fournier's gangrene, whose testicles are necrotic and I'm working with a -- excuse me, it's a motion detecter here; sorry about that -- working with our urologist as to whether or not the testicles can be saved. Generally speaking, although I may have in a handful of cases performed an orchiectomy for a person who is not transgender, in my practice, most of the overwhelming majority of cases for which I perform an orchiectomy would be for a transgender person.

Q And have you ever performed an orchiectomy on a cisgender man in the absence of pathology or diseased tissue?

A In the absence of a diagnosis of gender dysphoria, I may have performed orchiectomies in the past or, as we just discussed, cases of Fournier's gangrene,

for example, infection. It's conceivable I've performed them for other reasons that I can't recall right now. But as I said, generally speaking, when I perform an orchiectomy, it's for a diagnosis of gender dysphoria.

Q All right. Well, let me ask you this: If a cisgender male patient presented to you with healthy tissue, no pathology, no diagnosis, but he said I'd like you to perform an orchiectomy, is that a surgery you would perform?

A Those are generally not people I would see in my practice.

Q And why is that?

A Well, I'm not aware of a medical condition, unlike gender dysphoria, where an orchiectomy would be indicated. So if there were a particular reason for it, I would entertain that. As of now, that's not typically a person who I would see in my practice.

Q And this might be obvious, but focusing on a cisgender woman, do you ever perform a hysterectomy absent pathology or diseased tissue?

A So I don't -- I work with our gynecology team for a hysterectomy, so I would typically not perform hysterectomy. Mastectomy, yes, not infrequently.

Much of my previous practice was in breast reconstruction for cisgender women where it would not be uncommon to perform a mastectomy for someone who was at a hereditary or a genetic predisposition for cancer. Those are instances where a cisgender woman not only may undergo hysterectomy, but also oophorectomy or removal of her ovaries.

Q Absent a risk of -- absent a risk of cancer, have those surgeries been performed for cisgender women?

A Well, we all have a risk of cancer. It's a question of what -- how significant that risk may be in one hand -- the one hand. And it's on the other hand like many medical conditions where there are many options for treatment what the preference, what the goal is for that particular patient. So, in other words, one person may have a lower degree of cancer risk and opt for a mastectomy, one person may have a high degree of cancer risk and not opt for a mastectomy. So it's highly individualized and dependent upon the person and the condition.

Q If there were a cisgender woman with no risk of cancer, would you perform a mastectomy?

A I don't know that I've met anybody with no risk of cancer.

Q So it's the risk --

A Having a body part -- pardon me?
Q Go ahead.
A Having a body part may predispose someone to a particular pathology.
Q But it's the risk of cancer that would justify a mastectomy in a cisgender woman under the circumstances you're discussing, correct?
A There may be other reasons why a woman undergoes mastectomy and chooses to have reconstruction or not: Traumatic deformities, congenital reasons, infection reasons, cancer being one of those reasons.
Q In -- let's focus on transgender patients. In transgender patients, let's take a male to female surgical candidate, is an orchiectomy also going to sterilize that patient?
A Answer is it depends. Again, we don't necessarily know everyone's fertility status prior to the procedure.
Q Assuming he -- assuming the patient is fertile and can impregnate someone.
A Assuming the patient is fertile and can impregnate someone, if they undergo an orchiectomy, they would not be able to produce sperm, again unless they have chosen, which is part of our informed consent

process, to pursue sperm preservation.

Q Okay.

THE WITNESS: Excuse me one second again.

MR. CARLISLE: Okay.

(A discussion was held off the record.)

A And I apologize. Literally this never happens and right now there's a confluence of multiple ORs going, so I apologize.

Q That's okay. That's okay.

Were you finished answering?

A I was.

Q And it would be true then for female to male transgender surgery candidates that a hysterectomy would sterilize the patient?

A No. An oophorectomy, again, would sterilize a patient depending upon whether or not they had -- had any embryo preservation or egg preservation. Prior to a procedure, a hysterectomy would not allow someone to carry a fetus.

Q And thank you for that clarification.

All right. Follow-up after surgery. How often do you follow up with patients after you've performed a surgery -- a gender-confirmation surgery on them?

A So it depends on which particular procedure.

Q All right. Let's focus on male to female patients who get feminizing genital surgery. How often do you follow up with them?

A Well, if it were a stand-alone orchiectomy, for example, the typ- -- the procedure would be performed either as an outpatient or an overnight stay. We would typically see people about a week after surgery, then several weeks after surgery, then six weeks after surgery, then three months after surgery.

If the procedure included a vaginoplasty, the patient would be seen more frequently. Typically inpatient hospitalization on the order of five to seven days, follow-up in our office at postoperative day ten, follow-up in post -- on our -- in our office on postoperative day on or about 14. They would then return regularly for the first couple weeks to work with our pelvic floor physical therapists, assuming that they had construction of a vaginal canal, to work with the physical therapist on dilation. We would then see them again about six weeks after surgery, three months after surgery, one year after surgery and typically two years after surgery.

Q Great. And then for male to female surgical

candidates who have masculinizing genital surgery, how often do you see them after surgery?

A So I think you mean for the term female -- you've used the term male to female. I think you meant female to male which is now --

Q Correct.

A -- a dated term -- now a dated term. So we would refer to them as transmasculine patients. It would depend upon the nature of the procedure. If it's a phalloplasty, we would see them for -- for years.

Q And what about other procedures?

A So the only other -- well, generally for masculinizing genital surgery, the two categories would be either metoidioplasty or phalloplasty. Metoidioplasty is spelled m-e-t-o-i-d-i-o plasty, referring to length of the hormonally hypertrophied clitoris, which may or may -- may or may not be done with lengthening of the urethra.

Other surgery, for example, like hysterectomy would typically be followed by my partner. I wouldn't necessarily see a person who had a standalone hysterectomy.

Q Do you know how often your partner would see that person postop?

A If it was a standalone hysterectomy, typically my

partner, the urogynecologist, would do that. It would be quite common that those individuals would also undergo chest surgery, meaning mastectomy, and so it wouldn't be uncommon that we would both see them, but I would not follow independently a person who had a hysterectomy alone, as a standalone.

Q I see. What is the purpose of the follow-up meetings after surgery?

A Several. Assess the patient. And assessment means several things. Of course from the surgical standpoint to assist their healing, looking for any healing-related problems. Is there a specific procedure we're talking about now because it, of course, depends on the procedure.

Q Let's take vaginoplasty.

A So for vaginoplasty the follow-up would typically include an assessment of their healing, an assessment of their urination, beginning dilation and vaginal rinsing, assessing sensation, assessing their overall satisfaction with the procedure, ensuring that they have a stable situation, which is what much of our work up front is done by our social worker and navigator, meaning they have safe space, they have a safe and private place to dilate. Assessing their ability to return, for

example, to work, their ability to return to activities of daily living and then ultimately assessing whether or not the surgery has improved their gender dysphoria.

Q All right. Any other reasons for the follow-up visits?

A It's a general check in to see how they are -- to see how they're doing and how they're satisfied with surgery and see how their overall life and well-being are doing.

Q When you say you want to gauge how their gender dysphoria is doing post surgery, how do you do that?

A Well, we ask. We ask how they -- how the surgery has impacted them, how it's impacted their dysphoria and/or their overall life functioning as it pertains to personal or professional family goals and overall function.

Q So do you have any objective measure -- measurements of gender dysphoria in those visits?

A The patient -- patient-reported outcome.

Q And do you have any presurgery baseline data to compare the subjective reports post surgery related to gender dysphoria?

A So that's where the multi-disciplinary process

comes in. That's where -- our review of their letters and their current state of functioning and dysphoria and what the goal of surgery is.

Some patients may have undergone testing related to their gender dysphoria. Some patients may have undergone other psychological instruments or tests. That depends on the individual person.

Q And so if you have someone who's taken a psychological test before surgery, what kind of tests are you referring to?

A There's a variety of tests, and the nature of that would depend upon the person and what their mental health/professional felt was important prior to the procedure. If I felt there was a particular area that needed to be assessed or addressed, I would discuss that with their primary care and/or mental health profession.

Q And do you or your team administer that same test that the patient took before surgery during a follow-up visit?

A That's a hypothetical question, but in my practice I don't administer psych- -- psychological tests.

Q Okay. So post surgery during follow-ups, it sounds like the only measurements you take are based on subjective responses from the patients?

A We have a variety of research and clinical research. Patients may be asked to complete surveys that may include things like sexual function, overall well-being as part of their follow-up or as part of a clinical research study.

Q In the patients who participate in those studies, do you know whether there is objective data to compare the results from presurgery to after surgery?

A Yes, there may be pre and post, although I'm typically blinded as to -- as to who completes, and so I don't necessarily have the individual data on those tests or the results.

Q So in your own follow-up, all you know is what is reported to you from your patients during a -- a follow-up visit?

A And then overall results for a completion -- for people who have completed pre and postoperative studies. So that may not be the individual patient, but it does provide an overall overview of the practice in general for people who participate in a particular clinical study.

Q Okay. You have performed surgery on a number of prisoners, right?

A I estimate probably seven.

Q Okay. And from your report, I think one was in federal custody?
A Correct.
Q And the rest were in state custody in Illinois?
A Yes.
Q Okay. What kind of surgeries did you perform on those individuals?
A Vaginoplasty and mastectomy.
Q And when did you perform these surgeries, just an estimate?
A I would estimate that we perhaps started, a rough estimate, about a year, give or take ago.
Q So you've done all these prisoner surgeries within the past year?
A I -- I'd have to look specifically, but -- but that would be, I think, an estimate, yes.
Q Was the presurgical process -- and by that, I mean the informed consent process you described earlier, was that different for the prisoner surgeries than it was for your non-prisoner patients?
A We spent quite a bit of time working with the Illinois Department of Corrections. Some of it got hung up around COVID-related issues. But part of our process -- well, I -- and I can explain that process, but much of it also centered around safe

aftercare.

One of the examples of that is a medical facility that came online in Illinois where following discharge from the hospitals, people who are incarcerated are discharged to the medical facility. That was part of the coordination between our team and the Illinois Department of Correction around issues not only healing but dilation, vaginal rinsing, and recuperation.

Some of the other things that we -- with our patients who are incarcerated, in addition to the process we discussed, we have what we call a pathway to informed consent. So what that is, is patients in the Illinois system who are contemplating at this point vaginoplasty or mastectomy following being identified as transgender, being interested in pursuing medical interventions, being screened by the IDOC team would under- -- would gather for a webinar. I do that probably quarterly, again give or take, where the IDOC will gather people from various facilities, and I'll do a webinar regarding either vaginoplasty or mastectomy. So subsequent to that -- so that's a requirement for people prior to having a consultation. So if once they've been

screened and approved and then once they've followed the webinar, seen the webinar, had the opportunity to ask generic questions, because, of course, I can't give specific information until they're examined, then they may be deemed eligible for an in-person consultation.

Q For the prisoner patients you performed surgery on in the past year, were you made aware of their baseline mental health status?

A Yes. They're all screened by a mental health team through the Illinois Department of Corrections. There's also what's called a THAW, T-H-A-W, committee meeting. I participate in that when I'm able to, which is again a multi-disciplinary review of people who are contemplating surgical interventions.

Q And for your prisoner surgical patients, how many had underlying mental health comorbidities?

A I can't recall. I would estimate at least -- at least two who I can think of. It may be more, but I'd have to look specifically at -- at their records.

Q Okay. Did those comorbidities -- how did the comorbidities affect your decision whether to perform the surgery?

A Well, there may be a number of factors that affect my decision. So I have also declined to perform surgery on people who are incarcerated. And -- and again, that may be for a variety of reasons. That can be for medical reasons. It can be for mental health reasons. And so as how any condition would impact the decision to proceed with surgery, as we would with any patient contemplating surgery, we would work with -- with our colleagues, with their other care providers as well as with the patient to determine as to whether surgery is appropriate or indicated or safe.

Q You mentioned you've declined to perform surgery for prisoners. How many have of them have you declined to perform surgery for?

A So we typically see people in groups of three. I probably last saw a group within the last four to six weeks, and I can think of -- and so I can think of at least one person in the last group who, for the time being, I did not feel was ready for surgery. I discussed that with the IDOC team. We were all in agreement.

Q And among the prisoners you've declined for surgery, how many had mental health comorbidities that affected your decision to not perform surgery?

A That, I can't recall offhand.
Q Can you estimate?
A I can't estimate to the sense that -- to the -- to the sense that it would be, for example, a mental health comorbidity that would have -- cause me not to recommend surgery. As we said, there could be a variety of reasons why I might not recommend surgery.
Q All right. Let me ask you, why is a mental health comorbidity among the reasons you would decline to perform surgery on a patient?
A So there are several things that are important, and -- and this is not only in the context of gender-affirming or gender-confirming surgery. As a physician and surgeon, we care for people who have mental health conditions that doesn't necessarily preclude them from having surgery. But some of the things that we want to make sure are, of course, whether they're able and competent to provide consent for the procedure, specifically they're not delusional, for example, or psychotic or actively psychotic. We want to make sure that they're able to participate in their aftercare and the postoperative plan and that they will be compliant with the requirements to opt- -- of

aftercare so as to optimize their healing and their outcome.

We also want to know if there are any questions, whether medical or mental health, that may need optimization prior to surgery. Mental health conditions may impact, for example, pain control following surgery.

Q To your knowledge, have you ever performed gender-confirmation surgery on someone with borderline personality disorder?

A Yes.

Q What about antisocial personality disorder?

A That, I can't recall.

Q The -- how many patients have you performed surgery on who had borderline personality disorder?

A I would say a handful. That is a difficult condition, one which I would say requires significant collaboration with primary care and mental -- mental health professionals as to whether -- not that surgery may not benefit the person but whether they are an appropriate candidate for surgery.

Q Why does borderline personality disorder create a question of whether the patient is an appropriate candidate for surgery?

A Again, not speaking as a psychologist, but as a surgeon and speaking from my experience, as we've discussed, I think the ability to participate in one's aftercare is very important, to work collaboratively with our team and their other healthcare professionals. And to the extent that any condition would impair or impede that, that should be investigated prior to surgery. Now, it wouldn't necessarily preclude surgery, but it does require a management plan following surgery.

Q Have any of the prisoners you've performed gender-confirmation surgery on in the past year had borderline personality disorder?

A I don't believe so, but I -- I can't say for 100 percent certainty.

Q Have any of those prisoners been convicted of serious felonies?

A I don't necessarily know what a person is convicted of. Of course my assumption is if -- is if someone is incarcerated in the system that there is -- there has been a serious offense.

Q So do you know the length of the remaining sentence of any of the prisoners you've performed surgery on in the past year?

A I can't speak specifically to those prisoners, but

part of the process that we have in looking at candidacy for surgery does include a release date, and that largely focuses it -- focuses around aftercare and recuperation issues. Excuse me one second again. I apologize. Okay. I'm sorry.

Q That's all right. So you were talking about a release date. Is a -- why is release date important?

A Well, from the perspective of the procedure, we want to ensure again aftercare and optimize one's recovery. So we don't necessarily want someone to be in transition or in a transitional state during recuperation from surgery.

Q Is it better then for a prisoner to have a distant release date than a near one in terms of recuperation?

A I can't say distant or near is necessarily better. I would say that sufficient time to recuperate depending on the procedure. So, for example, recuperation following a mastectomy would be less than following a vaginoplasty.

Q What is sufficient time for a prisoner to recuperate from a vaginoplasty?

A So I would say for most of our individuals, generally by six weeks people have -- are usually

able to perform most activities of daily living. I tell them generally by three months that people can resume unrestricted activities. Now, having said that, that still requires ongoing dilation, for example, and that requires safe housing, privacy, work accommodations.

So I wouldn't perform a vaginoplasty, for example, on someone with a release date of three months in an incarcerated situation because of a potential concern for post-incarceration housing and social stability around still being able to meet perioperative needs.

Q And does the release date -- do you also factor in considerations like the -- the wait time for surgery and the time it takes to get hair removed in the --

A Yes.

Q -- genital area, for instance?

A Yes. So part of what we also did, and thank you for reminding me, was working with IDOC, the Illinois Department of Corrections, in terms of preoperative hair removal. What I will say is that our incarcerated patients probably have the best hair removal of -- of all of our patients. They're quite good about -- about that.

Q How long can it take to get the hair removal process complete, generally speaking?
A So I don't require for vaginoplasty every follicle to be removed because we can remove hair during surgery. I want the density and coarseness of hair to be reduced. I would say for many of or non-incarcerated patients, that may be three to four months of hair removal, whether laser or electrolysis. It may be a longer period of time for incarcerated patients because, as I've said, they -- those individuals have had the most complete hair removal generally speaking.
Q And if a surgeon required complete hair removal, it would require more time?
A I would require -- it would depend on the density and the coarseness and the distribution of hair and what that particular surgeon required.
Q But generally, yes, it would require more time?
A If a surgeon required 100 percent hair removal, that would take more than -- generally more than three to four months.
Q All right. You've agreed that only a few gender-confirmation surgeries have been performed on prisoners of the United States, correct?
A I don't know the denominator of that. I know the

ones -- the surgeries I've done and maybe, you know, I've heard of handfuls in the media, but I -- I don't know the total denominator.

Q All right. You would agree that these surgeries have all been performed recently?

A That, I'm not sure. My surgeries have been performed recently, but I can't speak to -- to others.

Q All right. Are you aware --

A I should say about a year. I apologize.

Q Excuse me. Are you aware of any systematic studies of the efficacy of surgery specific to prisoners?

A I am not -- in terms of gender-affirming surgery?

Q Yes, sir.

A I -- I'm sorry, can you repeat it? Any systematic studies?

Q Yeah.

A And by systematic, what -- what do you mean?

Q I don't mean to be too technical, but widespread studies of gender-confirmation surgery on prisoners.

A I may be familiar with case reports. I can't recall off the top of my head. I'm not familiar, for example, with a randomized controlled trial.

Q All right.

MR. CARLISLE: Kate, can you put up Exhibit 17, please?

(Witness Ms. Meltzer with request.)

(Exhibit 17 marked.)

Q All right. Dr. Schechter, do you see the report on your screen?

A I do.

Q All right. And this is a copy of your expert witness report in this case?

A Looks to be.

Q All right. Does this report contain all of the opinions you intend to render in this case?

A It contains my opinions regarding this case. I will say that, as I note in the report, I'm actively involved in teaching, research, and education. So I'm always acquiring new information. So if there's a particular, you know, aspect in this case, I would answer it. It's conceivable if you ask me something different, that my opinions may evolve over time.

Q Understood, but as -- as of today, right now, this is -- this report contains all your opinions, right?

A Pertaining to this particular case.

Q All right. And did you cite all the facts and data

supporting your opinions in this report?
A Well, if you're asking do I rely specifically only on, for example, studies or literature in this report, the answer to that would be no. Those are representative studies. I don't take any single study as dispositive of my opinions for reasons that I may differ with an author on particular topics. The studies may have been written or care may have evolved since the time a study has been published. As I said, my opinions are also based on my experience as well as my discussions with -- with colleagues.
Q All right. And how did you choose which studies to cite in this report then?
A I think studies which represented or illustrated particular points.
Q Which best illustrated those points?
A No. I -- I don't take any study as necessarily best. As I said, my opinions are not based off of a single -- single study.
Q Okay. Did you receive any assistance writing this report?
A No, aside from I -- these are my ideas and -- and they were memorialized by Mr. Falk but no other assistance than that.

Q Okay. Did you write this report recently?
A I -- I look at -- I'd have to look at the date, but yes, and it builds upon opinions in other cases.
Q All right. Have you used this report or a version of it in other cases?
A I have used portions of this in other cases.
Q Do you know which portions?
A No. I mean, probably my experience in the field, I think footnote No. 1, probably may be [audio issue]. Certainly updated things like my curriculum vitae, experience.
Q Understood.
MR. CARLISLE: Kate, can you go to page 10, please?
(Ms. Meltzer complies with request.)
Q All right, Dr. Schechter, do you see the section titled "Surgical Treatments for Gender Dysphoria"?
A Yes.
Q Let us know if we can make the text bigger or anything.
A Thank you. Right now I'm okay.
Q Okay. And so it looks like there's a list of surgeries from page 10 to 11. Are those the -- is that a complete list of surgeries that would be referred to as gender-confirmation surgeries?

A I would say again they incorporate the majority of procedures. It's probably not exhaustive.
Q Okay. What other kind of procedures might be included in this list then?
A Oh, can you -- let me look at the list then. Can you scroll? I can see -- let's see. Okay. (Witness reads to himself.) Hair removal, I don't see included in this.
Q All right.
A Body -- body contouring would be. And it looks like this is the list for transgender women. I think the next page has -- or the next paragraph has transgender men.
Q Yep. There it is, 31.
A Okay. One could include facial masculinizing procedures again, for example, hair -- hair reconstruction and body contouring as well.
Q Let me ask you specifically about breast augmentation. In cisgender patients, is breast augmentation a cosmetic procedure?
A Generally speaking, in cisgender women, breast augmentation is cosmetic.
Q And in -- I believe it's transmasculine patients -- was that the term -- is it cosmetic as well?
A Transfeminine.

Q Transfeminine?
A Yeah. No, I would consider that -- again, it would depend on the particular patient but in general would be reconstructive in nature because the basis is treating a medical condition of gender dysphoria.
Q The reconstructive nature of breast augmentation in transfeminine patients does not refer to a pathology or disease, correct?
A Well, it refers to the medical condition of gender dysphoria.
Q But it doesn't refer to diseased tissue when you say reconstructive, right?
A It -- it refers to the medical condition of gender dysphoria.
Q And so what is it about gender dysphoria specifically that makes it reconstructive in transfeminine patients?
A So it's alignment of one's identity with their body to treat the medical condition of gender dysphoria.
Q Can you explain that?
A Well, gender dysphoria refers to the distress that is related to the discordance between one's identity, their gender identity, and their body, typically secondary sexual characteristics.

Surgery, many of those listed above, gender-affirming surgeries, are designed to align body and identity as part of a multi-disciplinary treatment for gender dysphoria in appropriately identified and selected individuals.

Q So is the distress in a transfeminine patient about the chest caused by the appearance of having no breasts?

A That may be a component of it. Again, it would depend upon the particular patient.

Q Apart from the appearance, what else would cause the distress of a transfeminine patient's chest?

A A body not aligned with their identity.

Q So, in other words, because the body doesn't look like a woman's body, that causes distress?

A I would say it is the diagnosis of -- or the nature of the distress I would defer to our mental health professionals. My role is typically the surgical intervention. And in the surgical intervention, the goal is to establish congruence between one's body and one's identity.

Q And is it your understanding that if you fix the appearance of a transfeminine patient's chest, that will alleviate the gender dysphoria?

A I would say that surgery may be a component of a

multi-disciplinary process. So surgery is not performed in a vacuum, and so I don't perform surgery for individuals who have not received an assessment and who are not undergoing multi-disciplinary treatment. So I don't look at surgery as a standalone treatment but rather a component of multi-disciplinary care in appropriately-identified people.

Q I understand it's a multi-disciplinary process, but wouldn't you agree that the particular surgical component, when we're talking about breast augmentation for transfeminine patients, is related just to the appearance of the chest?

A The goal is congruence between body and identity. There may be -- as with all medical conditions, individual -- individuals may vary. So I don't look at surgery, again, as a standalone treatment for it. The people who I've operated on are diagnosed with the medical condition of gender dysphoria, which means they've received assessments prior to surgery. So I don't perform the procedure for people who haven't received that assessment, and I wouldn't look at surgery as a standalone treatment.

Q All right. Let me ask about orchiectomy. Is an

orchiectomy a cosmetic procedure in transfeminine women?

A No. I would consider it, again, reconstructive in an appropriately-identified person with the medical condition of gender dysphoria who's received, excuse me, the appropriate assessment and preoperative evaluation.

Q It's not reconstructive of diseased tissue, right?

A Again, it's for a medical condition, and -- and so I would liken it to someone who undergoes perhaps a mastectomy or oophorectomy who doesn't have a diag-- who doesn't have -- whose tissue itself may not contain pathology but part of an overall treatment for a condition.

Q All right. I'm just not understanding what reconstructive purpose an orchiectomy serves in a transfeminine woman.

A Well, when I use the term in this context reconstructive, I'm referring to the term medically necessary. So treatment used to prevent disease and/or progression of a disease or a condition. Excuse me one second.

Q Let's say you have a -- as I'm sure you've had, a transfeminine patient who has been on hormone therapy and has the circulating sex hormones of a

woman. If you perform an orchiectomy on that patient, what specific purpose does it serve?

A So can you replay -- repeat the scenario?

Q Yes. You have a transfeminine patient who's been on hormone therapy and has the same circulating sex hormones of a woman because of the therapy, what specific purpose will an orchiectomy serve in that patient?

A So again, I don't manage the hormones. I would defer that to my medical colleagues. Following orchiectomy, typical -- typically individuals who are on an androgen blocker, a testosterone blocker, typically in the US referred to spironolactone, that is typically discontinued because the major source of testosterone production has been removed. As to whether changes in dosing regimens or hormone regimens need to be performed, I would defer that to my medical colleagues.

Q So again, what -- so orchiectomy, if I'm understanding you, has the same effect. It would allow -- orchiectomy allows the patient to stop the hormone therapy? Is that what I heard?

A Typically after orchiectomy, people would discontinue the use of spironolactone. Spironolactone is what's cons- -- well, it's a

diuretic, a water pill, but it's also an androgen-blocking medication. So most often patients are on a feminizing hormone regimen; for example, some estrogen preparation or perhaps estrogen or progesterone, and then some medication to block testosterone.

As with any medication or intervention, there may be risks associated with that, dehydration being one. Electrolyte imbalance is another. Removing the testicles by performing an orchiectomy allows people to typically discontinue the use of their androgen blocker, not always. People may take some other medicines, but generally speaking allows people to remove the androgen-blocking medication.

Q So is it true then that hormone therapy is an alternative treatment to surgery because it has the same effect?

A So I don't prescribe hormone, and I would defer management of hormones to my medical colleagues. And it's not that hormones are necessarily an alternative to surgery. As I say in my report, not all individuals who are transgender necessarily undergo surgery. And so for what's appropriate for any patient involves a discussion with that